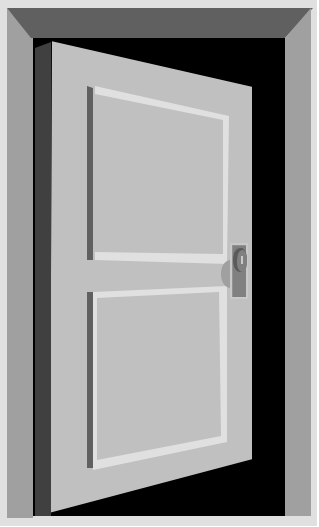
Medicare Home Health Benefit

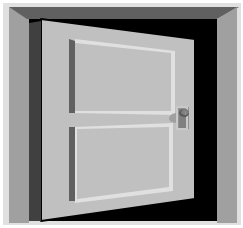
Home Health Eligibility

- Must meet all 4 qualifying criteria
- (1) Skilled Need
  - You must need:
    - intermittent skilled nursing (other than solely venipuncture) or
    - physical therapy or
    - speech language pathology or
    - continue to need occupational therapy



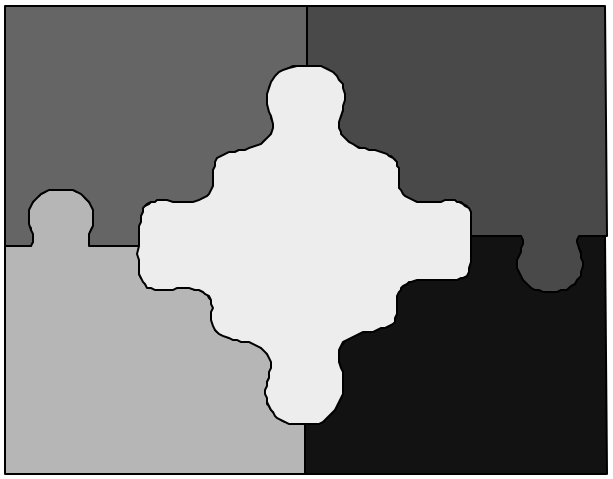
Home Health Eligibility

- (2) You are homebound
  - normal inability to leave
  - leaving takes a considerable & taxing effort
  - absences are for an infrequent or short duration or to receive health care treatment
    - BIPA 2000-Can attend State certified/licensed or accredited day care program and religious services
- (3) You are under the plan of care established & periodically reviewed by a physician
- (4) You receive the services from a Medicare participating HHA



Home Health Coverage

- Part-time or intermittent skilled nursing
- Part-time or intermittent home health aide
- Physical therapy
- speech-language pathology
- occupational therapy
- medical social services
- medical supplies
- durable medical equipment
- injectible osteoporosis drug



The Home Health Prospective Payment System

Home Health Prospective Payment System (PPS)

- Laws Governing PPS:
  - Balanced Budget Act of 1997 (BBA)
  - Omnibus Consolidated and Emergency Supplemental Appropriations Act for FY 1999
  - Balanced Budget Refinement Act of 1999
- Proposed rule published October 28, 1999
- Final rule published July 3, 2000
- October 1, 2000 effective date for all home health agencies (HHAs)

What is included in the PPS Unit of Payment?

- Covered home health services paid on a reasonable cost basis as of the date of enactment of the BBA
- Six Disciplines
  - skilled nursing
  - home health aide
  - physical therapy
  - speech-language pathology
  - occupational therapy
  - medical social services
- Non-Routine Medical Supplies

What is not included in the PPS unit of payment?

- Durable Medical Equipment
- Osteoporosis Drug

What is the unit of payment under PPS?

- 60 Day Episode Payment
  - Continuous recertification for eligible beneficiaries
- Split Percentage Payment
  - BBA Eliminates PIP -cash flow/pay& chase
  - 60/40 First Episodes
  - 50/50 Subsequent Episodes
  - HHAs submit requests for anticipated payment (RAP) for initial percentage payment
  - HHAs submit claims for final percentage payment

What are the adjustments to the PPS unit of payment?

- CASE MIX
  - Abt Case Mix Research Study
  - 80 Case Mix Groups (80 Home Health Resource Groups-HRGs)
  - 23 OASIS items
- Geographic Differences in Wages
  - Latest pre-floor & pre-reclassified hospital wage index
  - Based on site of service of the beneficiary
- Annual Updates for Inflation Required by Law

When can I restart the 60 day episode clock during an existing episode?

- Two Intervening Events Trigger a New 60 Day Episode Clock:
  - Beneficiary Elected Transfer
  - Discharge & Return to Same HHA
- The original 60 day episode payment will be closed out with a “Partial Episode Payment Adjustment” (PEP Adjustment)
- PEP Adjustment to original 60 day episode is based on billable visit dates as a proportion of 60

Significant Change in Condition Payment Adjustment (SCIC Adjustment)

- SCIC Adjustment occurs when:
  - a beneficiary experiences a significant change in condition during the 60 day episode not envisioned in the original plan of care.
  - a beneficiary's significant change in condition requires a change in case mix level & new physician orders reflecting change in course of treatment.

SCIC Adjustment Calculation

- Both Parts of the SCIC Adjustment are calculated using the span of time the patient was at the case mix level prior to and after the significant change
- SCIC adjustment does not restart the 60 day episode clock
- SCIC occurs within a given 60 day episode
- SCIC adjustment reflects proportional payments during a given episode both before and after the significant change in condition

Low Utilization Payment Adjustment (LUPA)

- Reduces 60 Day Episode Payment for Minimal Service Delivery
- Four or fewer visit threshold
- Wage adjusted average per visit amounts per discipline

Outlier Payments

- Optional in Law
- Capped at 5% of total outlays
- Cost Outlier Payments
- No need for long stay outlier payments- continuous recertifications for eligible beneficiaries

Consolidated Billing

- HHAs must furnish all covered home health services (EXCEPT DME) while patient is under the POC directly or under arrangement and bill Medicare directly
- HHAs will no longer be able to unbundle covered home health services (EXCEPT DME) under the home health POC to an outside supplier.
- Balanced Budget Refinement Act of 1999 removed DME from consolidated billing